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Montana. Division of Workers' Compensation
Medical provider's guide

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Medical Provider's Guide

Department of Labor and Industry

DIVISION OF WORKERS' COMPENSATION

5 South Last Chance Gulch
Helena, MT 59601

Revised July 1, 1988

PAM 7

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western meadowlark

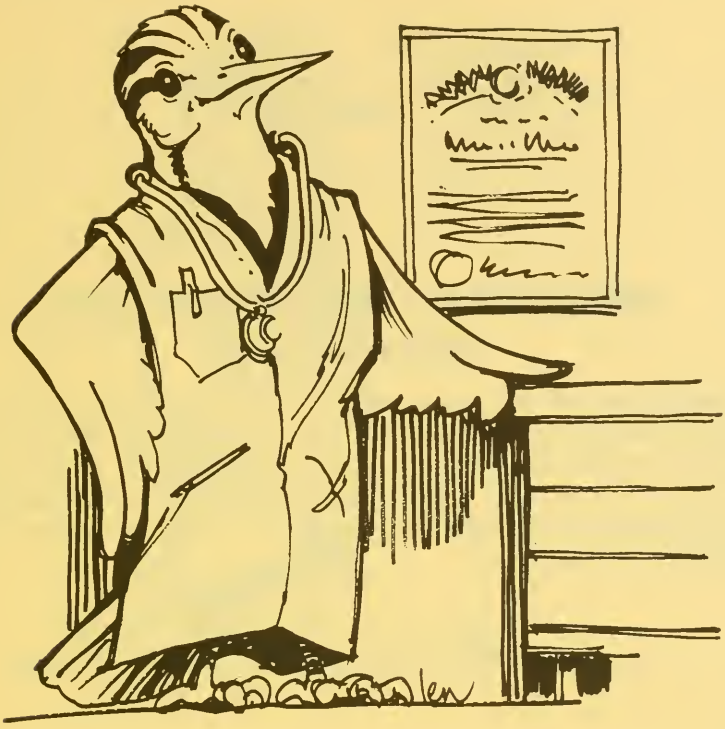
The western meadowlark is a familiar Montana resident, often seen singing form fenceposts and utility wires in grasslands around the state. We can only wonder how Lewis and Clark managed to omit this common praire-dwelling member of the blackbird family from their species' lists. The oversight prompted John James Audobon to name it *Sturnella neglecta*, or "little overlooked starling."

Easily identified by the black "V" on its bright yellow breast, this handsome species is the state bird in Kansas, North Dakota, Oregon, and Wyoming as well as Montana! The haunting flutelike song of the meadowlark has no doubt contributed to the bird's extraordinary popularity which won Montana's school children vote as state bird and secured that official designation in statute passed by the 1931 legislature

About 70% of the meadowlark's diet consists of insects such as cutworms and grasshoppers, making it a friend to the farmer and rancher. But also requiring it to fly south in the wintertime in search of better hunting grounds in Utah, Neveda, Arizona, New Mexico and northern Mexico. Only a few hardy individuals in the western part of the state are tough enough to be year-round residents. The rest return in March or April to build their simple ground nests, and hopefully raise a clutch of around five eggs in the uncertainty of Montana climate.

Sturnella neglecta

APR 27 1994



This Medical Providers' Guide is designed to assist you and your staff to process payments for workers' compensation injuries. It explains:

- what workers' compensation insurance is and how it works
- what medical costs are covered
- what information and forms are required
- **WHERE TO SEND YOUR BILLING STATEMENTS FOR THE QUICKEST HANDLING**
- where to get assistance when you need help in acquiring necessary information

Keep this booklet as a reference guide for your office personnel.

Published by:
DIVISION OF WORKERS' COMPENSATION
5 SOUTH LAST CHANCE GULCH
HELENA, MT 59601

WORKERS' COMPENSATION INSURANCE

Montana's no-fault workers' compensation law has been in effect since 1915. It establishes a program of benefits to almost all workers in the state who are injured on the job. Benefits are paid only for those injuries that occur during the course of employment. Neither general liability nor health and accident policies are substitutes for workers' compensation insurance.

HOW COVERAGE IS OBTAINED

Employers in Montana may obtain coverage through private insurance companies licensed to write workers' compensation insurance in the state or through the State Compensation Insurance Fund, which is a state operated insurance program. Certain employers or groups of employers may self-insure if approved in advance by the Division.

MEDICAL BENEFITS PROVIDED

All reasonable and necessary medical services are covered, provided that the injury or disease is job related.

Payments for medical services will be made in accordance with the relative value schedule of fees and charges adopted by the Division.

Payment for hospital services after January 1, 1988 are also subject to rates adopted by the Division.

CHOICE OF PHYSICIAN

The injured worker may select the physician to provide initial treatment for work related injuries; however, authorization is required from the insurer when the worker wishes to change treating physicians. Any physician licensed by the appropriate authority to practice within the state may provide services, provided the treatment is within the scope and limits of their license.

The insurer should be advised by the treating physician when unusual treatment is required for critical cases. Except in an emergency, approval of the insurer must be obtained before the injured worker is referred to a medical specialist for consultation.

COVERAGE CEASES

In certain circumstances when the injured worker has made a financial settlement with the insurer, medical coverage will no longer be provided for a particular injury. When this occurs, the insurer will notify the medical providers and the injured worker.

REQUIRED FORMS

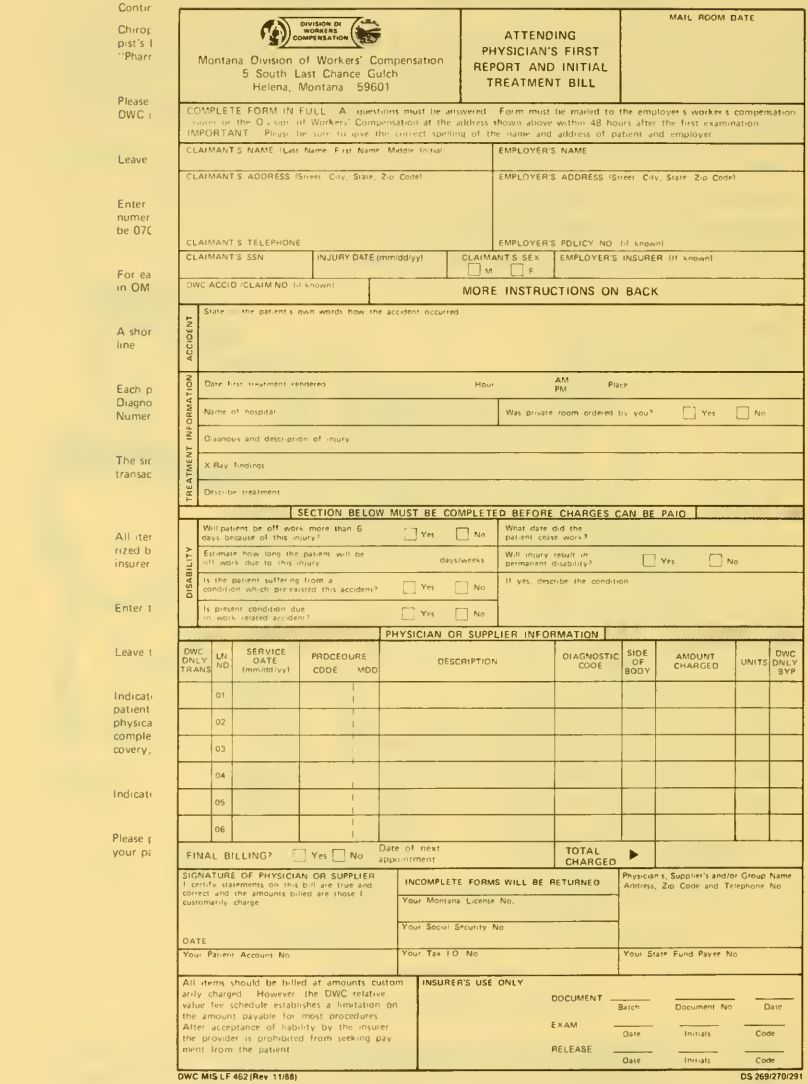
Before the medical payment process can begin, certain forms must be completed and sent to the insurance company or its representative. The medical providers have the responsibility of completing and submitting the following required forms:

- Form LF 462 "Attending Physician's First Report and Initial Treatment Bill" (see page 6)
- Form LF 463 "Attending Chiropractor's First Report and Initial Treatment Bill" (see page 7)
- Form LF 464 "Chiropractor's Supplemental Report" (see page 8)
- Form LF 465 "Attending Dentist's First Report and Initial Treatment Bill" (see page 9)
- Form LF 466 "Physical Therapist's First Report and Initial Treatment Bill" (see page 10)
- Form LF 468 "General Medical Continued Billing", State Compensation Insurance Fund form, (see page 11)
- Form LF 472 "Pharmacist's Claim for Supplies" (see page 12)

A supply of these forms can be obtained by writing to:

Division of Workers' Compensation
5 S. Last Chance Gulch
Helena, Montana 59601

- Standard Form HCFA 1500 may be substituted for any of the above. However, initial bills submitted on this form may be delayed until responses to specific questions requested in the standard forms above, have been received by the insurer.



MEDICAL SERVICE PROVIDER INFORMATION AND INSTRUCTIONS

This form has been designed for use by physicians to submit their first bill to Montana workers' compensation insurers for services rendered due to work related injuries. HCFA 1500 can also be used, I
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DIVISION OF WORKERS' COMPENSATION

Montana Division of Workers' Compensation
5 South Last Chance Gulch
Helena, Montana 59601

ATTENDING PHYSICIAN'S FIRST REPORT AND INITIAL TREATMENT BILL

MAIL ROOM DATE

COMPLETE FORM IN FULL. All questions must be answered. Form must be mailed to the employer's workers' compensation insurer or the Division of Workers' Compensation at the address shown above within 48 hours after the first examination.
IMPORTANT: Please be sure to give the correct spelling of the name and address of patient and employer.

CLAIMANT'S NAME (Last Name, First Name, Middle Initial) | EMPLOYER'S NAME

CLAIMANT'S ADDRESS (Street, City, State, Zip Code) | EMPLOYER'S ADDRESS (Street, City, State, Zip Code)

CLAIMANT'S TELEPHONE | EMPLOYER'S POLICY NO. (If known)

CLAIMANT'S SSN | INJURY DATE (mm/dd/yy) | CLAIMANT'S SEX ☐ M ☐ F | EMPLOYER'S INSURER (If known)

DWC ACCID./CLAIM NO. (If known) | MORE INSTRUCTIONS ON BACK

ACCIDENT
State, in the patient's own words, how the accident occurred

TREATMENT INFORMATION
Date first treatment rendered | Hour AM PM | Place

Name of hospital | Was private room ordered by you? ☐ Yes ☐ No

Diagnosis and description of injury

X-Ray findings

Describe treatment

SECTION BELOW MUST BE COMPLETED BEFORE CHARGES CAN BE PAID

DISABILITY
Will patient be off work more than 6 days because of this injury? ☐ Yes ☐ No | What date did the patient cease work?

Estimate how long the patient will be off work due to this injury: days/weeks | Will injury result in permanent disability? ☐ Yes ☐ No

Is the patient suffering from a condition which pre-existed this accident? ☐ Yes ☐ No | If yes, describe the condition

Is present condition due to work related accident? ☐ Yes ☐ No

PHYSICIAN OR SUPPLIER INFORMATION

OWC ONLY TRANS	LN NO.	SERVICE DATE (mm/dd/yy)	PROCEDURE CODE	MOD	DESCRIPTION	DIAGNOSTIC CODE	SIDE OF BODY	AMOUNT CHARGED	UNITS	OWC ONLY SYP
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FINAL BILLING? ☐ Yes ☐ No | Date of next appointment | TOTAL CHARGED ▶

SIGNATURE OF PHYSICIAN OR SUPPLIER
I certify statements on this bill are true and correct and the amounts billed are those I customarily charge.
DATE

INCOMPLETE FORMS WILL BE RETURNED
Your Montana License No.
Your Social Security No.

Physician's, Supplier's and/or Group Name, Address, Zip Code and Telephone No.

Your Patient Account No. | Your Tax I.D. No. | Your State Fund Payee No.

All items should be billed at amounts customarily charged. However, the DWC relative value fee schedule establishes a limitation on the amount payable for most procedures. After acceptance of liability by the insurer, the provider is prohibited from seeking payment from the patient.

INSURER'S USE ONLY
DOCUMENT Batch | Document No. | Date
EXAM Date | Initials | Code
RELEASE Date | Initials | Code

DWC MIS LF 462 (Rev 11/88) DS 269/270/291

FORM LF 462

ATTENDING PHYSICIAN'S FIRST REPORT and INITIAL TREATMENT BILL

Submitted by the attending physician, including emergency room services immediately after treatment.

MEDICAL SERVICE PROVIDER INFORMATION AND INSTRUCTIONS

This form has been designed for use by chiropractors to submit their first bill to Montana workers compensation insurers for services rendered due to work related injuries. HCFA 1500 can also be used, h
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DIVISION OF WORKERS' COMPENSATION

Montana Division of Workers' Compensation
5 South Last Chance Gulch
Helena, Montana 59601

ATTENDING CHIROPRACTOR'S FIRST REPORT AND INITIAL TREATMENT BILL

MAIL ROOM DATE

COMPLETE FORM IN FULL. All questions must be answered. Form must be mailed to the employer, employer's insurer or the Division of Workers' Compensation at the address shown above within 48 hours after the first examination. IMPORTANT: Please be sure to give the correct spelling of the name and address of patient and employer.

CLAIMANT'S NAME (Last Name, First Name, Middle Initial) | EMPLOYER'S NAME

CLAIMANT'S ADDRESS (Street, City, State, Zip Code) | EMPLOYER'S ADDRESS (Street, City, State, Zip Code)

CLAIMANT'S TELEPHONE | EMPLOYER'S POLICY NO. (If known)

CLAIMANT'S SSN | ACCIDENT DATE (mm/dd/yy) | CLAIMANT'S SEX ☐ M ☐ F | EMPLOYER'S INSURER (If known)

DWC ACCID./CLAIM NO. (If known) | MORE INSTRUCTIONS ON BACK

ACCIDENT

State in the patient's own words how the accident occurred

TREATMENT

Present Subjective Complaints

Date first treatment rendered | Hour AM PM | Place

Clinical diagnosis and description of injury

Is this condition predominantly unilateral? ☐ Yes ☐ No If yes please indicate _____ right _____ left

X Ray findings

Has this patient been under the care of another health care provider for this injury? ☐ Yes ☐ No

Was this case a referral to you? ☐ Yes ☐ No If yes, by whom?

Have you consulted with previous doctors concerning this case? ☐ Yes ☐ No

Have you secured permission from the insurer to treat? ☐ Yes ☐ No | If yes, from _____ to _____ | Who granted permission? | Date

SECTION BELOW MUST BE COMPLETED BEFORE CHARGES CAN BE PAID

DISABILITY

Will patient be off work more than 6 days because of this injury? ☐ Yes ☐ No | What date did the patient cease work?

In your opinion, was the accident the principal cause of these symptoms? ☐ Yes ☐ No | If no, please describe

BILLING INFORMATION

DWC ONLY TRANS	LN NO	SERVICE DATE (mm/dd/yy)	PROCEDURE CODE	MDD	DESCRIPTION	DIAGNOSTIC CODE	SIDE OF BODY	AMOUNT CHARGED	UNITS	DWC ONLY BYP
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FINAL BILLING? ☐ Yes ☐ No | Date of next appointment | TOTAL CHARGED ▶

SIGNATURE OF CHIROPRACTOR
I certify statements on this bill are true and correct and the amounts billed are those I customarily charge

DATE

INCOMPLETE FORMS WILL BE RETURNED

Your Montana License No.

Your Social Security No.

Chiropractor's group name, address, zip code and telephone number

Your Patient Account No. | Your Tax I.D. No. | Your State Fund Payee No.

All items should be billed at amounts customarily charged. However, the DWC relative value fee schedule establishes a limitation on the amount payable for most procedures. After acceptance of liability by the insurer the provider is prohibited from seeking payment from the patient.

INSURER'S USE ONLY

DOCUMENT Batch | Document No. | Date

EXAM Date | Initials | Code

RELS Date | Initials | Code

DWC MIS LF 463 (Rev. 1/88) OS 269/270

FORM LF 463

ATTENDING CHIROPRACTOR'S FIRST REPORT and INITIAL TREATMENT BILL

Submitted by the attending chiropractor within 48 hours of the initial treatment.

DIVISION OF WORKERS' COMPENSATION

Montana Division of Workers' Compensation
5 South Last Chance Gulch
Helena, Montana 59601

CHIROPRACTOR'S SUPPLEMENTAL REPORT

MAIL ROOM DATE

COMPLETE FORM IN FULL. This supplemental report is to be submitted at the end of the first 15 days and every 30 days thereafter during the treatment period. Use LF468 for continued billing.

CLAIMANT'S NAME (Last Name, First Name, Middle Initial)	EMPLOYER'S NAME
CLAIMANT'S ADDRESS (Street, City, State, Zip Code)	EMPLOYER'S ADDRESS (Street, City, State, Zip Code)
CLAIMANT'S TELEPHONE	EMPLOYER'S POLICY NO. (If known)

CLAIMANT'S SSN	ACCIDENT DATE (mm/dd/yy)	CLAIMANT'S SEX ☐ M ☐ F	EMPLOYER'S INSURER (If known)

DWC ACCID./CLAIM NO.(If known)

NONREPORTING MAY TERMINATE PAYMENTS.

ACCIDENT

Is the patient still under treatment? ☐ Yes ☐ No

Has the patient returned to work? ☐ Yes ☐ No Date _____

Is this a reopening of a prior treated accident? ☐ Yes ☐ No If yes, explain.

TREATMENT STATUS

Indicate status of patient's physical condition: (Add narrative report, if desired.)

☐ Acute ☐ Chronic Reoccurring ☐ Patient failed to return

☐ Moderate ☐ Asymptomatic ☐ Dismissed with residual

☐ Mild ☐ Requesting additional treatment time

Date last treated _____ Date of next appointment _____

Anticipated frequency of treatment _____ Estimated healing period _____

Present subjective complaints

Present objective findings

Has this condition been aggravated during the course of treatment? ☐ Yes ☐ No

If yes, please explain.

Describe any conditions or findings not previously found or reported.

Do you anticipate recovery to a preinjury status? ☐ Yes ☐ No

If no, why?

SIGNATURE OF CHIROPRACTOR OR SUPPLIER I certify statements on this report are true and correct. DATE	INCOMPLETE FORMS WILL BE RETURNED Your Montana License No. Your Social Security No.	Chiropractor's, supplier's and/or group name, address, zip code and telephone number.
Your Patient Account No.	Your Tax I.D. No.	Your State Fund Payee No.

INSURER'S USE ONLY

OWC-MIS LF 464 (Rev. 1/88) OS 269/270

FORM LF 464

CHIROPRACTOR'S SUPPLEMENTAL REPORT

Submitted by the chiropractor every 30 days during the treatment period.

MEDICAL SERVICE PROVIDER INFORMATION AND INSTRUCTIONS

This form has been designed for use by dentists to submit their first bill to Montana workers' compensation insurers for services rendered

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DIVISION OF WORKERS' COMPENSATION

Montana Division of Workers' Compensation
5 South Last Chance Gulch
Helena, Montana 59601

ATTENDING DENTIST'S FIRST REPORT AND INITIAL TREATMENT BILL

MAIL ROOM DATE

COMPLETE FORM IN FULL. All questions must be answered. Form must be mailed to the employer's workers compensation insurer or the Division of Workers' Compensation at the address shown above within 48 hours after the first examination. IMPORTANT: Please be sure to give the correct spelling of the name and address of patient and employer.

CLAIMANT'S NAME (Last Name, First Name, Middle Initial)	EMPLOYER'S NAME
CLAIMANT'S ADDRESS (Street, City, State, Zip Code)	EMPLOYER'S ADDRESS (Street, City, State, Zip Code)
CLAIMANT'S TELEPHONE	EMPLOYER'S POLICY NO. (If known)

CLAIMANT'S SSN	ACCIDENT DATE (mm/dd/yy)	CLAIMANT'S SEX M F	EMPLOYER'S INSURER (If known)

DWC ACCIO /CLAIM NO. (If known) | MORE INSTRUCTIONS ON BACK.

CHECK ONE — Pre Treatment Estimate & Plan (Necessary if over $100.00) — Actual Services

State in patient's own words how teeth were injured. List accident related teeth by number and how injured (i.e. loosened, avulsed, fractured, etc.) Include which surface. Describe initial treatment. Remarks for unusual services.

Date first Treated _____

Be sure to mark the form either for pre treatment estimate OR actual services. Forms not indicated either way will be returned.

BILLING INFORMATION

DWC Only Trans	LN No.	Service Date (mm/dd/yy)	Procedure Code	Mod.	Description	Diagnostic Code	Tooth No.	Amount Charged	Units	DWC Only BYP
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IS THIS A FINAL BILLING? Yes No — Date of Next Appointment — TOTAL CHARGED ►

SIGNATURE OF DENTIST OR SUPPLIER
I certify statements on this bill are true and correct and the amounts billed are those I customarily charge.

DATE

INCOMPLETE FORMS WILL BE RETURNED

Your Montana License No.

Your Social Security No.

DENTIST'S, SUPPLIERS, AND/OR GROUP NAME Address, Zip Code and Telephone No.

Your Patient Account No. | Your Tax I.D. No. | Your State Fund Payee No.

All items should be billed at amounts customarily charged. However, fees in excess of those authorized by the Division of Workers' Compensation will not be paid. After acceptance of liability by the insurer, the provider is prohibited from seeking payment from the patient.

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EXAM	Date	Initials	Code
RELS	Date	Initials	Code

DWC MIS LF 465 (Rev. 7/88) — 05 269-270

FORM LF 465

ATTENDING DENTIST'S FIRST REPORT and INITIAL TREATMENT BILL

Submitted to the workers' compensation insurer by the attending dentist within 48 hours after the first examination.

MEDICAL SERVICE PROVIDER INFORMATION AND INSTRUCTIONS

This form has been designed for use by physical therapists to submit their first bill to Montana workers' c
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DIVISION OF WORKERS' COMPENSATION

Montana Division of Workers' Compensation
5 South Last Chance Gulch
Helena, Montana 59601

PHYSICAL THERAPIST'S FIRST REPORT AND INITIAL TREATMENT BILL

MAIL ROOM DATE

COMPLETE FORM IN FULL All questions must be answered Form must be mailed to the employer's worker's compensation insurer or the Division of Workers' Compensation at the address shown above within 48 hours after the first examination IMPORTANT Please be sure to give the correct spelling of the name and address of patient and employer

CLAIMANT'S NAME (Last Name First Name Middle Initial)

EMPLOYER'S NAME

CLAIMANT'S ADDRESS (Street City State Zip Code)

EMPLOYER'S ADDRESS (Street City State Zip Code)

CLAIMANT'S TELEPHONE

EMPLOYER'S POLICY NO (If known)

CLAIMANT'S SSN | ACCIDENT DATE (mm dd yy) | CLAIMANT'S SEX ☐ M ☐ F | EMPLOYER'S INSURER (If known)

DWC ACCID CLAIM NO (If known)

MORE INSTRUCTIONS ON BACK

ATTENDING PHYSICIAN | NATURE OF INJURY

EVALUATION AND TREATMENT PLAN

COPYING OF PHYSICIAN'S REFERRAL MUST BE ATTACHED

EVALUATION

IMPRESSION

RECOMMENDATION

BILLING INFORMATION

DWC ONLY TRANS	LN NO	SERVICE DATE (mm dd yy)	PROCEDURE CODE	PROCEDURE MOD	DESCRIPTION	DIAGNOSTIC CODE	SIDE OF BODY	AMOUNT CHARGED	UNITS	DWC ONLY BYP
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FINAL BILLING? ☐ Yes ☐ No If yes, attach exit report

TOTAL CHARGED ▶

SIGNATURE OF PHYSICAL THERAPIST
I certify statements on this bill are true and correct and the amounts billed are those I customarily charge

DATE

INCOMPLETE FORMS WILL BE RETURNED

Your Montana License No

Your Social Security No

Physical Therapist and/or Group Name, Address, Zip Code and Telephone No

Your Patient Account No

Your Tax I D No

Your State Fund Payee No

All items should be billed at amounts customarily charged However the DWC relative value fee schedule establishes a limitation on the amount payable for most procedures After acceptance of liability by the insurer the provider is prohibited from seeking payment from the patient

INSURER'S USE ONLY

DOCUMENT Batch Document No Date

EXAM Date Initials Code

RELS Date Initials Code

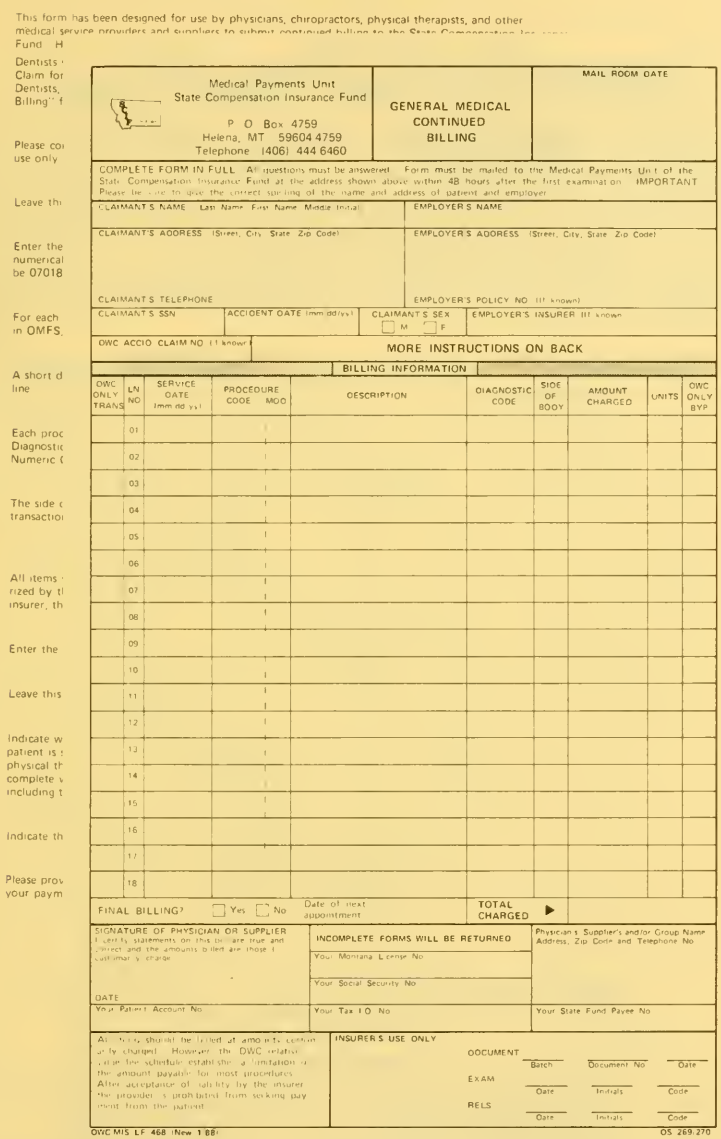
DWC MIS LF 466 (Rev 1/88) DS 269/270

FORM LF 466

PHYSICAL THERAPIST'S FIRST REPORT and INITIAL TREATMENT BILL

Submitted by the physical therapist within 48 hours after the first examination. If patient is still recovering, submit every 30 days indicating the status of the patient.

MEDICAL SERVICE PROVIDER INFORMATION AND INSTRUCTIONS



This form has been designed for use by physicians, chiropractors, physical therapists, and other medical service providers and suppliers to submit continued billing to the State Compensation Insurance Fund. H

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Medical Payments Unit
State Compensation Insurance Fund

P O Box 4759
Helena, MT 59604 4759
Telephone (406) 444 6460

GENERAL MEDICAL
CONTINUED
BILLING

MAIL ROOM DATE

COMPLETE FORM IN FULL All questions must be answered Form must be mailed to the Medical Payments Unit of the State Compensation Insurance Fund at the address shown above within 48 hours after the first examination IMPORTANT Please be sure to type the correct spelling of the name and address of patient and employer

CLAIMANT'S NAME (Last Name First Name Middle Initial)

EMPLOYER'S NAME

CLAIMANT'S ADDRESS (Street, City, State Zip Code)

EMPLOYER'S ADDRESS (Street, City, State Zip Code)

CLAIMANT'S TELEPHONE

EMPLOYER'S POLICY NO (If known)

CLAIMANT'S SSN

ACCIDENT DATE (mm/dd/yy)

CLAIMANT'S SEX ☐ M ☐ F

EMPLOYER'S INSURER (If known

OWC ACCID CLAIM NO (If known)

MORE INSTRUCTIONS ON BACK

BILLING INFORMATION

OWC ONLY TRANS	LN NO	SERVICE DATE (mm dd yy)	PROCEDURE CODE	MOD	DESCRIPTION	DIAGNOSTIC CODE	SIDE OF BODY	AMOUNT CHARGED	UNITS	OWC ONLY BYP
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FINAL BILLING? ☐ Yes ☐ No Date of next appointment TOTAL CHARGED ▶

SIGNATURE OF PHYSICIAN OR SUPPLIER
I certify statements on this bill are true and correct and the amounts billed are those I customarily charge

DATE

INCOMPLETE FORMS WILL BE RETURNED

Your Montana License No

Your Social Security No

Your Tax I D No

Physician's Supplier's and/or Group Name Address, Zip Code and Telephone No

Your Patient Account No

Your State Fund Payee No

All items should be billed at amounts customarily charged However the DWC relative value fee schedule establishes a limitation on the amount payable for most procedures After acceptance of liability by the insurer the provider is prohibited from seeking payment from the patient

INSURER'S USE ONLY

DOCUMENT Batch Document No Date

EXAM Date Initials Code

RELS Date Initials Code

OWC MIS LF 468 (New 1 88)

OS 269.270

FORM LF 468

GENERAL MEDICAL CONTINUED BILLING

May be used by physicians, chiropractors, physical therapists, and other medical service providers and suppliers to submit continued billing to the State Compensation Insurance Fund. Undue delays in payment may be avoided if medical notes/reports are submitted with this form.

HOW TO COMPLETE THIS FORM

All questions must be answered unless indicated otherwise. The form must be mailed to the employer's workers' compensation insurer or the Division of Workers' Compensation. Please be sure to give the correct

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DIVISION OF WORKERS' COMPENSATION

Montana Division of Workers' Compensation
5 South Last Chance Gulch
Helena, Montana 59601

PHARMACIST'S CLAIM FOR SUPPLIES

MAIL ROOM DATE

DIRECTIONS — COMPLETE THIS FORM IN ITS ENTIRETY BY PRINTING IN INK OR USING A TYPEWRITER. DETAILED INSTRUCTIONS ARE ON THE BACK.

CLAIMANT'S NAME (Last Name, First Name, Middle Initial)		EMPLOYER'S NAME	
CLAIMANT'S ADDRESS (Street, City, State, Zip Code)		EMPLOYER'S ADDRESS (Street, City, State, Zip Code)	
CLAIMANT'S TELEPHONE		EMPLOYER'S POLICY NO. (If known)	
CLAIMANT'S SSN	ACCIDENT DATE (mm/dd/yy)	CLAIMANT'S SEX ☐ M ☐ F	EMPLOYER'S INSURER (If known)
DWC ACCID./CLAIM NO. (If known)		MORE INSTRUCTIONS ON BACK.	
PRESCRIBING PHYSICIAN'S NAME		PHYSICIAN'S CITY	INSURER'S USE ONLY

LN NO	DATE OF SALE MO DAY YR	Rx NUMBER	NATIONAL DRUG CODE	DESCRIPTION	NEW OR REF	QUANTITY REF NO	QUANTITY UNITS	PRICE	OWC ONLY BYP
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17									
					TOTAL CHARGED ▶				

SIGNATURE OF PHARMACIST OR SUPPLIER
I certify statements on this bill are true and correct and the amounts billed are those I customarily charge

DATE

INCOMPLETE FORMS WILL BE RETURNED

Pharmacist's supplier's and/or group name, address, zip code and telephone number

Your Social Security No.

Your Patient Account No.

Your Tax I.D. No.

Your State Fund Payee No.

Payment cannot be made on refills that are older than 30 days from the date of last sale without a renewal prescription from the attending physician. All items should be billed at amounts customarily charged. However, fees in excess of those authorized by the Division of Workers' Compensation are subject to reduction. Only under special circumstances will over-the-counter drugs be paid. After acceptance of liability by the insurer, the provider is prohibited from seeking payment from the patient.

INSURER'S USE ONLY

DOCUMENT	Batch	Document No.	Date
EXAM	Date	Initials	Code
RELS	Date	Initials	Code

OWC MIS LF 472 (Rev. 2/88)

OS 269/270

FORM LF 472
PHARMACIST'S CLAIM FOR SUPPLIES

COVERAGE IDENTIFICATION

The Division of Workers' Compensation has the responsibility to identify coverage on the injured employee. Only after coverage has been identified can the bill payment process begin. There are nearly 30,000 industrial accidents in Montana annually, and each requires insurer identification. The timeliness of medical provider payments can be greatly improved if certain basic information is provided on all bills for services.

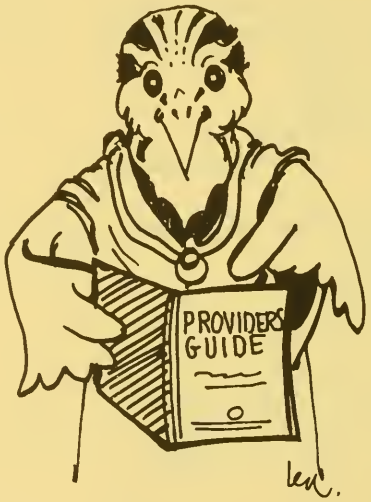
Information the Division

- **Needs:**
    1. Workers' compensation "accident or claim" number (once available)
    2. Name of patient
    3. Name of Employer (Owner or Commercial Name)
    4. Complete address of patient's employer
    5. Date of accident
    6. Part of body injured
- Would also like to have:
    1. Employer's Worker Compensation Insurance Company
    2. Patient's Social Security number
    3. Medical provider's Federal Tax I.D. number or Social Security number.
    4. Medical Provider's State Fund payee number for accidents covered by the State Compensation Insurance Fund. For injured Federal and Railroad Employees see page 19.

LIABILITY FOR MEDICAL EXPENSE

After determination that the injury or disease was job related and an insurance company accepts liability, payment for the medical service becomes the responsibility of the proper workers' compensation insurer. The injured worker is no longer liable for any fee or charge once the insurer has accepted liability. If an insurer denies liability, however, the cost of medical treatment becomes the responsibility of the patient or his health insurer.

Costs of medical services furnished by the provider extraneous to the accident are the responsibility of the patient.



DISPUTED MEDICAL CLAIMS

Disputes arising over workers' compensation medical claims will be resolved by the Division of Workers' Compensation. Written application may be made by the medical provider or the injured worker.

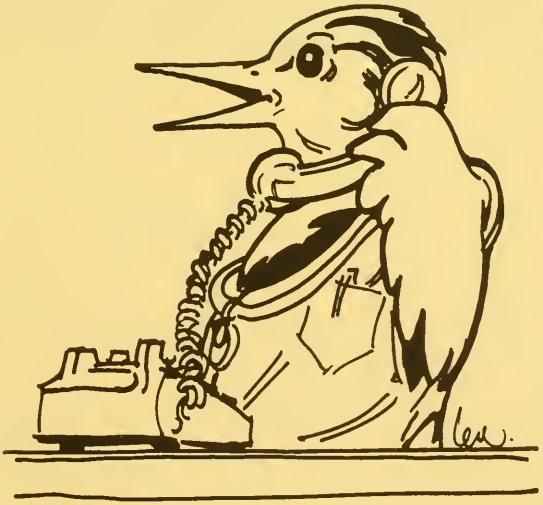
HELP IN COVERAGE IDENTIFICATION

Necessary steps to be taken in identifying coverage:

- Check with injured workers' employer.
- Use the Division's toll free line for assistance:
  Phone 1-800-332-6102

If you have tried and cannot identify coverage, please send bill to:
Division of Workers' Compensation
Attention: Accident Cataloging
5 South Last Chance Gulch
Helena, MT 59601

We will assist you in routing your bill to the proper payment office, but **payments will be delayed.**



UNINSURED EMPLOYERS

Occasionally an employer will not carry the required workers' compensation coverage. In those circumstances, we recommend you forward your billings to the employer and employee. Should the Uninsured Employers Fund start paying medical benefits, providers will be notified.

In addition to filing a claim against the Uninsured Employers Fund, the law allows the employee to file a damage action or independent cause of action against the employer. The employee can also enter into an agreement with the Division which allows the Division to assign to the employee any benefits collected from the employer.

Employers convicted of avoiding their responsibility to provide coverage, misrepresenting or falsifying employment records, or refusing to pay premiums when due, are subject to a $50,000 fine, ten years in prison, or both.

WHERE TO SEND FORMS AND BILLS FOR SERVICE

The medical provider's bill for services can be processed more rapidly if a"claim" or"accident" number is placed on the bill before you send it in. You may obtain this number by calling our toll-free number

1-800-332-6102

For quicker payment, it is to the providers' advantage to send statements directly to the insurer or the insurer's representative making the payment. Ask the claimant to provide you with his or the workers' compensation insurer's name and address. This information is posted in the work place. Mail your reports and bills, properly numbered, or with a photocopy of the accident report, to the claimant's insurer.

Every insurer and self-insured employer has been assigned an adjuster code. To find out the proper mailing address to send your bills:

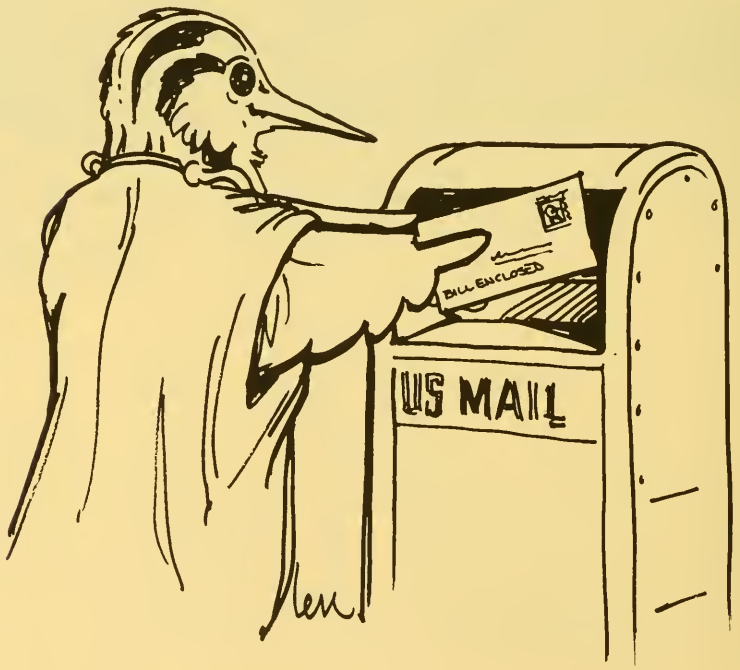
First — Identify the adjuster code in Table"A" associated with the insurance company,

or

Identify the adjuster code in Table"B" associated with the self-insured employer,

Then — Go to Table"C" to find the proper mailing address associated with the adjuster code.

Tables A, B, and C are current as of July 1988 but are subject to change. The Division will periodically update these tables as necessary.

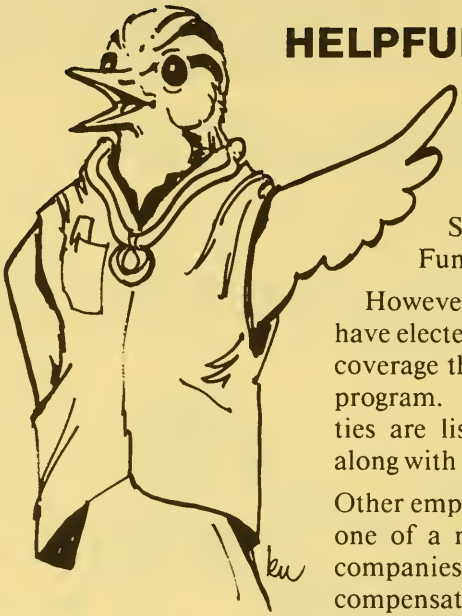


FEDERAL GOVERNMENT & RAILROAD EMPLOYEES

Employees working for the United States Government are not covered by Montana Workers' Compensation laws nor are employees of railroads engaged in interstate commerce. However, these employees are covered by Federal laws when injured in an industrial accident. Bills for services may be sent to:

- Federal Government Employees:
  Office of Workers' Compensation
  1961 Stout Street
  Drawer 3558
  Denver, Colorado 80294
  Phone: (303) 844-5407 or (303) 844-4839
- Montana Rail Link Employees:
  Benefits Coordinator
  Montana Rail Link
  P.O. Box 8779
  101 International Way
  Missoula, Montana 59807
  Phone: (406) 523-1500
- Union Pacific Railroad Co. Employees:
  (as Maintenance of Way Employees)
  Union Pacific Railroad
  P.O. Box 1592
  Pocatello, Idaho 83204
  Phone: (208) 236-5415

  (all other employees)
  Union Pacific Railroad
  Employee Health Systems
  120 South Railroad Avenue
  Pocatello, Idaho 83204
  Phone: (208) 236-5215
- Soo Line Railroad Co. Employees:
  Director, General Claims
  Soo Line Railroad Company
  Soo Line Building
  P.O. Box 530
  Minneapolis, Minnesota 55440
  Phone: (612) 347-8000



HELPFUL HINTS

State and some city, county, municipal and school district employees are covered by the State Compensation Insurance Fund.

However, certain cities and counties have elected, under a 1985 law, to obtain coverage through a group self-insurance program. These select cities and counties are listed on the next two pages, along with their adjuster's identification.

Other employees may be covered by any one of a number of private insurance companies authorized to write workers' compensation insurance in Montana or the employer may self-insure. It is best to call the employer to make certain. If you need help, use the toll free line (see page 15) mentioned under **"Help in Coverage Identification".**

SELF-INSURED GROUPS CITIES

The following cities have elected to provide their workers' compensation insurance through a group self-insurance program known as **Montana Municipal Insurance Authority**. Claims and medical bills should be sent to:

Gates, McDonald & Company
22 West Sixth Avenue
Helena, MT 59601
Phone: (406) 442-3885

CITIES

Alberton
Anaconda
Belgrade
Billings
Boulder
Bozeman
Bridger
Brockton
Browning
Butte
Cascade
Chinook
Choteau
Circle
Columbia Falls
Columbus
Conrad
Cut Bank
Deer Lodge
Dillon
Dutton
Ekalaka
Ennis
Fairfield
Fort Benton
Fort Peck
Glasgow
Glendive
Great Falls
Hamilton
Havre
Helena
Hot Springs
Joliet
Kalispell
Kevin
Laurel
Lavina
Lewistown
Libby
Lima
Livingston
Malta
Medicine Lake
Melstone
Miles City
Missoula
Moore
Plains
Plenty Wood
Plevna
Polson
Poplar
Red Lodge
Richey
Ronan
Scobey
Shelby
Sheridan
Sidney
Stevensville
Sunburst
Superior
Thompson Falls
Three Forks
Troy
Valier
Virginia City
West Yellowstone
Westby
Whitefish
Whitehall
Winnett
Wolf Point

This list is current as of July 1988. Additional cities may be added from time to time.

SELF-INSURED GROUPS COUNTIES

The following counties have elected to provide their workers' compensation insurance through a group self-insurance program known as **MACO Workers' Compensation Trust**. Medical bills should be sent to:

Corroon & Black Management, Inc.
21 North Last Chance Gulch, Suite 205
Helena, MT 59601
Phone: (406) 442-1178

COUNTIES

Big Horn
Blaine
Broadwater
Carbon
Cascade
Choteau
Custer
Daniels
Dawson
Fallon
Fergus
Flathead
Gallatin
Garfield
Glacier
Golden Valley
Granite
Hill
Jefferson
Lake
Lewis & Clark
McCone
Madison
Meagher
Mineral
Missoula
Musselshell
Park
Petroleum
Phillips
Pondera
Powder River
Powell
Prairie
Ravalli
Richland
Roosevelt
Rosebud
Sanders
Sheridan
Stillwater
Sweetgrass
Teton
Toole
Wibaux
Yellowstone

TABLE A
INSURANCE COMPANIES DIRECTORY

ADJUSTER CODES	INSURANCE COMPANY
01	Aetna Casualty & Surety Company
01	Aetna Casualty & Surety of Illinois
41	Affiliated F. M. Insurance Company
25	Agricultural Insurance Company
02	AIU Insurance Company
22	Alaska Pacific Assurance Company
18	All West Insurance Company
46	Allianz Insurance Company
19	Allied Mutual Insurance Company
18	Allstate Insurance Company
25	American & Foreign Insurance Company
05	American Automobile Insurance Company
18	American Casualty Company of Reading, PA
18	American Centennial Insurance Company
03	American Economy Insurance Company
05	American Employers Insurance Company
05	American Guarantee & Liability Insurance Company
12	American Hardware Mutual Insurance Company
02	American Home Assurance Company
05	American Insurance Company
31	American Manufacturing Mutual Insurance Company
31	American Motorist Insurance Company
16	American Mutual Insurance Company of Boston
16	American Mutual Liability Insurance Company
25	American National Fire Insurance Company
16	American Policyholders Insurance Company
03	American States Insurance Company
05	American Zurich Insurance Company
11	Argonaut Insurance Company
11	Argonaut Midwest Insurance Company
11	Argonaut Northwest Insurance Company
05	Associated Indemnity Corporation
11	Assurance Company of America
42	Athena Assurance Company
25	Atlantic Mutual Insurance Company
01	Automobile Insurance Company of Hartford
02	Birmingham Fire Insurance Company of Pennsylvania

TABLE A

ADJUSTER CODES	INSURANCE COMPANY
20	Bituminous Casualty Corporation
05	Bituminous Fire & Marine Insurance Company
46	Boston Old Colony Insurance Company
47	Carriers Insurance Company
25	Centennial Insurance Company
22	Century Indemnity Company
44	Charter Oak Fire Insurance Company
18	Chicago Insurance Company
25	Church Mutual Insurance Company
22	Cigna Insurance Company
22	Cigna Fire Underwriters Insurance
22	Cigna Property & Casualty
25	Cimarron Insurance Company
29	City Insurance Company
02	Commerce & Industry Insurance Company
46	Commercial Insurance Company of Newark
05	Commercial Union Insurance of America
18	Cornpass Insurance Company
20	Connecticut Indemnity Company
18	Continental Casualty Company
46	Continental Insurance Company
25	Cumis Insurance Society, Inc.
12	Dakota Fire Insurance Company
20	EBI Insurance Company
18	Economy Fire & Casualty Company
06	Electric Mutual Liability Insurance Company
18	Employers Casualty Company
05	Employers Fire Insurance Company
35	Employers Insurance Company of Wausau
12	Employers Mutual Casualty
18	Enterprise Insurance Company
47	Excalibur Insurance Company
18	Fairmont Insurance Company
01	Farmington Casualty Company
18	Federal Insurance Company
05	Federated Mutual Insurance Company
31	Federated Rural Electric Insurance Corporation
05	Federated Service Insurance Company
46	Fidelity & Casualty Company of NY
45	Fidelity & Guarantee Insurance Underwriters

TABLE A

ADJUSTER CODES	INSURANCE COMPANY
20	Fire & Casualty Insurance Company of Connecticut
05	Fireman's Fund Insurance Company
46	Firemen's Insurance Company of Newark, NJ
00	First General Insurance Company
18	First Horizon Insurance Company
34	First National Insurance Company of America
00	First Southern Insurance Company
18	Florists' Mutual Insurance Company
46	Forum Insurance Company
05	Fremont Indemnity Company
25	General Accident Insurance Company of America
34	General Insurance Company of America
46	Glens Falls Insurance Company
25	Globe Indemnity Company
02	Granite State Insurance Company
25	Great American Insurance Company
48	Great Global Assurance Company
18	Great Northern Insurance Company
24	Great West Casualty Company
21	Gulf Insurance Company
46	Harco National Insurance Company
27	Hartford Accident & Indemnity Company
27	Hartford Casualty Insurance Company
27	Hartford Fire Insurance Company
18	Hawkeye Security Insurance Company
05	Highlands Insurance Company
29	Home Indemnity Company
29	Home Insurance Company
18	Houston General Insurance Company
47	Ideal Mutual Insurance Company
22	Indemnity Insurance Company of North America
18	Indiana Lumbermens Mutual Insurance
18	Industrial Indemnity Company of Northwest
18	Industrial Indemnity Company
22	Insurance Company of North America
02	Insurance Company of State of Pennsylvania
46	Insurance Corporation of Hanover
46	Intercontinental Insurance Company
48	Intermountain Insurance Company
18	International Indemnity Company

TABLE A

ADJUSTER CODES	INSURANCE COMPANY
18	International Insurance Company
11	Iowa Mutual Insurance Company
25	John Deere Insurance Company
46	Kansas City Fire & Marine Company
18	Lancer Insurance Company
11	Liberty Insurance Corporation
11	Liberty Mutual Fire Insurance
11	Liberty Mutual Insurance Company
12	London Guarantee & Accident
18	Lumbermen's Underwriting Alliance
31	Lumbermens Mutual Casualty Company
11	Maryland Casualty Company
18	MIC Property & Casualty Insurance Corporation
16	Michigan Mutual Insurance Company
23	Mid-Century Insurance Company
18	Midland Insurance Company
15	Millers Mutual Fire Insurance Company of Texas
25	Millers Mutual Insurance Association of Illinois
12	Millers National Insurance Company
11	Mission American Insurance Company
18	Mission Insurance Company
18	Mission National Insurance
40	Mountain West Farm Bureau Mutual
25	National Farmers Union Property & Casualty Company
18	National Fire Insurance Company of Hartford
25	National Indemnity Company
05	National Surety Corporation
02	National Union Fire Insurance Company of Pittsburgh
26	Nationwide Mutual Fire Insurance Company
26	Nationwide Mutual Insurance
26	Nationwide Property & Casualty Insurance Company
02	New Hampshire Insurance Company
27	New York Underwriters
25	Newark Insurance Company
46	Niagara Fire Insurance Company
25	North American Specialty Insurance Company
18	North River Insurance Company
18	Northbrook Indemnity Company
18	Northbrook National Insurance
18	Northbrook Property & Casualty

TABLE A

ADJUSTER CODES	INSURANCE COMPANY
05	Northern Assurance Company
11	Northern Insurance Company of NY
39	Northwestern National Casualty
39	Northwestern National Insurance Co. of Milwaukee, WI
25	Occidental Fire & Casualty
30	Old Republic Insurance Company
00	Pacific Compensation Insurance Company
22	Pacific Employers Insurance Company
18	Pacific Indemnity Company
18	Pennsylvania National Mutual Casualty Insurance Company
25	Petroleum Casualty Company
25	Phico Insurance Company
12	Phoenix Assurance Company of NY
44	Phoenix Insurance Company of Hartford
18	Planet Insurance Company
18	Preferred Risk Mutual Insurance Company
18	Protective Insurance Company
18	Providence Washington Insurance Company
42	Ramsey Insurance Company, Incorporated
18	Ranger Insurance Company
18	Reliance Insurance Company
32	Republic Western Insurance Company
31	Rockwood Insurance Company
25	Royal Indemnity Company
25	Royal Insurance Company of America
46	Security Insurance Company of Hartford
21	Select Insurance Company
25	Sentry Indemnity Company
25	Sentry Insurance Company
42	St. Paul Fire & Marine Insurance Company
42	St. Paul Guardian Insurance Company
42	St. Paul Mercury Insurance Company
01	Standard Fire Insurance Company
43	State Farm Fire & Casualty Company
18	Sun Insurance Office, Ltd.
18	Texas Employers Insurance Company
18	Texas General Indemnity Co.
18	Tokio Marine & Fire Insurance Company
36	Transamerica Insurance Company

TABLE A

ADJUSTER CODES	INSURANCE COMPANY
36	Transamerica Premier Insurance Company
18	Transcontinental Insurance Company
47	Transit Casualty Company
18	Transport Insurance Company of Des Moines
18	Transportation Insurance Company
44	Travelers Indemnity Company of Illinois
44	Travelers Indemnity Company of Rhode Island
44	Travelers Indemnity Company of America
44	Travelers Indemnity Company
44	Travelers Insurance Company
23	Truck Insurance Exchange
27	Twin City Fire Insurance Company
45	U.S. Fidelity & Guaranty Insurance Company
25	Unigard Security Insurance Company
18	Union Standard Insurance Company
18	United Pacific Insurance Company
25	United States Fire Insurance
05	Universal Underwriters Insurance Company
18	Utica Mutual Insurance Company
18	Valley Forge Insurance Company
18	Vigilant Insurance Company
35	Wausau Underwriters Insurance Company
18	Westchester Fire Insurance Company
03	Western Casualty & Surety Company
18	Western Employers Insurance Company
25	Western Fire Insurance Company
25	Western Indemnity Company, Incorporated
35	Worldwide Underwriters Insurance Company
05	Zurich American Insurance Company of Illinois
05	Zurich Insurance Company

TABLE B
SELF-INSURED EMPLOYER ADJUSTER CODES

CODES	SELF-INSURED EMPLOYER
05	Albertson's, Incorporated
18	ANR Freight Systems
04	ASARCO, Incorporated
11	Ash Grove Cement West, Incorporated
11	AT&T Communications
22	Borden, Incorporated
11	Champion International Corporation
09	Chevron Resources Company
25	Circle K Corporation
10	Cominco-American, Incorporated
31	Conoco, Incorporated
31	Conoco Pipe Line Company
13	Consolidated Freightways, Incorporated
01	Continental Baking Company
11	Cyprus Mines Corporation
05	Ernst Home Centers
41	F. H. Stoltze Land & Lumber Company
11	Georgia-Pacific Corporation
11	Golden Sunlight Mines, Incorporated
28	Holly Sugar Corporation
11	K-Mart Corporation
33	Louisiana-Pacific Corporation
17	MACO Workers' Compensation Trust
18	Montana Deaconess Medical Center
26	Montana Municipal Insurance Authority
37	Montana Power Company
44	Nabisco, Incorporated
31	Osco Drug, Incorporated
30	Peabody Coal Company
18	Phillips Petroleum Company
44	Plum Creek Timber Company
20	Rosauer's Supermarkets

TABLE B
ADJUSTER CODES SELF-INSURED EMPLOYER

11 . . . .Shell Pipeline Corporation
11 . . . .Shell Western E & P, Incorporated
20 . . . .Sisters of Charity of Providence of Montana
31 . . . .Skaggs Alpha Beta
41 . . . .Stoltze-Connor Lumber Company
11 . . . .Stone Container Corporation
11 . . . .Union Oil Company of California
07 . . . .Union Tank Car Company
38 . . . .U.S. West Communications, Incorporated (Mountain Bell)
49 . . . .Western Energy Company
08 . . . .Western Fruit Express Company

TABLE C
ADJUSTER ADDRESS DIRECTORY

ADJUSTER CODES — MAILING ADDRESS

01 . . . .Aetna Casualty & Surety Company
600 Central Avenue
Great Falls, MT 59401

02 . . . .American International Adjustment Company
625 Central Avenue West
Suite 202
Great Falls, MT 59404

03 . . . .American States Insurance Company
P.O. Box 5747
Helena, MT 59604

04 . . . .ASARCO, Inc.
Mr. Harry Payne
P.O. Box G
East Helena, MT 59635
(406) 227-5311
OR
ASARCO, Inc.
Mr. Lloyd Doney
P.O. Box 868
Troy, MT 59935-0868
(406) 295-5882

05 . . . .Baumgardner-Sayler Adjusters
P.O. Box 233
Helena, MT 59624-0233
OR
Baumgardner-Sayler Adjusters
P.O. Box 22543
Billings, MT 59104-2543

06 . . . .Big Sky Adjusters
P.O. Box 3443
Butte, MT 59701-3443

07 . . . .Billings Claim Service
P.O. Box 3441
Billings, MT 59103

TABLE C
ADJUSTER CODES MAILING ADDRESS

08 . . . .Burlington Northern Railroad
Manager Claims Division
P.O. Box 948
Havre, MT 59501-0948

09 . . . .Chevron Resources Company
Star Route 2, Box 365
Nye, MT 59061

10 . . . .Cominco Fertilizers
Division of Cominco American
P.O. Box 638
Garrison, MT 59731-0638

11 . . . .Compensation Adjusters, Inc.
P.O. Box 2899
Missoula, MT 59806-2899

12 . . . .Connor & Company
P.O. Box 2042
Great Falls, MT 59405-2042

13 . . . .Consolidated Freightways, Inc.
P.O. Box 4670
Portland, OR 97208-4670

14 . . . .Continental Insurance Company
P.O. Box 1587
Great Falls, MT 59403

15 . . . .Cook Insurance Adjusters
2104 Livingston
Southgate Station, Box 20124
Missoula, MT 59801

16 . . . .CORETTE, SMITH, POHLMAN, ALLEN
Attorneys-at-Law
P.O. Box 509
Butte, MT 59701-0509

17 . . . .Corroon & Black Management, Inc.
Box 566
Helena, MT 59624

TABLE C
ADJUSTER CODES — MAILING ADDRESS

18 ....Crawford & Company
P.O. Box 1317
Billings, MT 59103-1317
OR
Crawford & Company
P.O. Box 3007
Great Falls, MT 59403-3007
OR
Crawford & Company
P.O. Box 1316
Glendive, MT 59330-1316
OR
Crawford & Company
1502 Gold
Bozeman, MT 59715
OR
Crawford & Company
P.O. Box 4517
Helena, MT 59601-4517
OR
Crawford & Company
832 West Central
Missoula, MT 59801
OR
Crawford & Company
P.O. Box 2397
Kalispell, MT 59901

19 ....Glen L. Drake
Attorney-at-Law
38 South Last Chance Gulch
Helena, MT 59601

20 ....EBI Insurance Company
36 North Last Chance Gulch
Suite 400
Helena, MT 59601

21 ....Equitable Adjusting Company
P.O. Box 2023
Billings, MT 59103-2023

TABLE C
ADJUSTER CODES — MAILING ADDRESS

22 . . . .ESIS, INC.
625 Central Avenue West
Great Falls, MT 59404

23 . . . .Farmers Insurance Group
P.O. Box 21477
Billings, MT 59104-1477
OR
Farmers Insurance Group
P.O. Box 2646
Great Falls, MT 59405

24 . . . .Frontier Adjustment Services
P.O. Box 31373
Billings, MT 59103-1373

25 . . . .GAB Business Services
P.O. Box 20739
Billings, MT 59104-0739
OR
GAB Business Services
P.O. Box 3326
Butte, MT 59701-3326
OR
GAB Business Services
P.O. Box 2065
Great Falls, MT 59403-2065
OR
GAB Business Services
P.O. Box 4107
Missoula, MT 59806-2848
OR
GAB Business Services
Claims Manager
P.O. Box 551
Helena, MT 59601
OR
GAB Business Services
Claims Manager
1117 North 7th Avenue
Bozeman, MT 59715

TABLE C
ADJUSTER CODES — MAILING ADDRESS

OR
GAB Business Services, Inc.
Claims Manager
P.O. Box 957
Kalispell, MT 59901
OR
GAB Business Services, Inc.
Claims Manager
519 Main Street
Miles City, MT 59301

26 ....Gates McDonald & Company
P.O. Box 838
Helena, MT 59624-0838

27 ....Hartford Insurance Group
P.O. Box 2348
Great Falls, MT 59403-2348

28 ....Holly Sugar Corporation
P.O. Box 1168
Sidney, MT 59270-1168

29 ....Home Insurance Company
CPCU Claims Manager
6000 South Ulster Street
Englewood, CO 80111

30 ....Industrial Injury Claims Service
P.O. Box 22203
Billings, MT 59104-2203

31 ....Intermountain Claims
848 Main Street
P.O. Box 50626
Billings, MT 59105-0626

32 ....Jensen Adjusting Company
30 East Washington
Kalispell, MT 59901

33 ....Louisiana Pacific Corporation
P.O. Box 4007
Missoula, MT 59801

TABLE C
ADJUSTER CODES MAILING ADDRESS

34 . . . .Missoula SAFECO Co.
P.O. Box 2759
Missoula, MT 59806-2759

35 . . . .Monser & Associates
P.O. Box 20144
Missoula, MT 59801-0144

36 . . . .Montana Claims Service of Blgs
926 Main Street
11 Main Plaza
Billings, MT 59105

37 . . . .Montana Power Company
Mr. C. J. Woods
40 East Broadway
Butte, MT 59701

38 . . . .U.S. West Communications
(Mountain Bell)
P.O. Box 1716
Helena, MT 59624-1716

39 . . . .Mountain States Regional Ctr.
5670 Greenwood Plaza Bldg.
Suite 501
Englewood, CO 80111

40 . . . .Mountain West Farm Bureau
502 South 19th
Bozeman, MT 59715

41 . . . .Scott Wetzel Service, Inc.
833 East 400 S, Ste 104
Salt Lake City, UT 84012

42 . . . .St. Paul Fire & Marine Insurance Co.
P.O. Box 3149
Great Falls, MT 59403-3149

43 . . . .State Farm Fire & Casualty
P.O. Box 20699
Billings, MT 59104-0699

TABLE C

ADJUSTER CODES — MAILING ADDRESS

44 . . . .Travelers Insurance Co.
(Constitution State Services)
P.O. Box 5018
Great Falls, MT 59403-5018

45 . . . .U.S. Fidelity & Guaranty
P.O. Box 6107
Helena, MT 59624-6107

46 . . . .Underwriters Adjusting Co.
P.O. Box 21454
Billings, MT 59104-1454

47 . . . .Underwriters Adjusting Company
for Western Guaranty Fund
P.O. Box 5735
Boise, ID 83005-5735

48 . . . .Underwriters Adjusting Company
for Western Guaranty Fund
P.O. Box 21454
Billings, MT 59104-1454

49 . . . .Western Energy Company
16 East Granite
Butte, MT 59701

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